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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH </div>																
1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Patuxent River</u> c. LENGTH OF STAY IN b <u>1 1/2 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Station Hospital, USNAS, Patuxent River</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> St. Mary's b. COUNTY <u>St. Mary's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lexington Park</u> d. STREET ADDRESS <u>38 W. Rennell</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Arthur Wayne ADAMS</u>			4. DATE OF DEATH Month <u>November</u> Day <u>10</u> Year <u>1966</u>			5. SEX <u>Male</u>			6. COLOR OR RACE <u>Caucasian</u>							
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>11 APR 1946</u>			9. AGE (In years last birthday) <u>20</u> yrs. <table border="1" style="display: inline-table;"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>			IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.														
Months	Days	Hours	Min.													
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Jet Engine mechanic</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Navy</u>			11. BIRTHPLACE (State or foreign country) <u>Indiana</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William Earl Adams</u>					14. MOTHER'S MAIDEN NAME <u>Martha Marie Ramsey</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes give war or dates of service) <u>2 MAY 64-Pres</u>			16. SOCIAL SECURITY NO. <u>376 48 3814</u>			17. INFORMANT <u>Personnel office, USNAS, PAXRIVMD</u>			Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Injuries</u> <u>Multiple Extreme</u> 866X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____																
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Aircraft accident</u>													
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>3:30 p.m.</u> <u>NOV 10 1966</u>			20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Runway, USNAS</u>		20f. (City or town) <u>Patuxent River</u> (State) <u>St. Mary's</u> (County) <u>Maryland</u>									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																
ACTUAL SIGNATURE <u>[Signature]</u>			EXAMINER'S NAME (Type) <u>J. L. Smith</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22. DATE SIGNED <u>10 NOV 66</u>							
23a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Nov. 15, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City, town or county) <u>Arlington</u> (State) <u>Virginia</u>									
24. FUNERAL DIRECTOR <u>W. Clarke Mattingley</u> <u>Leonardtown, Maryland</u>					25a. REC'D BY REGISTRAR <u>[Signature]</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>											
DATE <u>NOV 16 1966</u>																

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MEMORANDUM FOR THE RECORD

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16178

CERTIFICATE OF DEATH

16177

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN			c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL DAMERON			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First MYRTLE Middle EVELYN Last ALLEN				4. DATE OF DEATH Month NOVEMBER Day 2 Year 1966			
5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/23/1922		9. AGE (In years lost birthday) 43 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ALVIN ALLEN				14. MOTHER'S MAIDEN NAME LUCY YOUNG			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-16-3339		17. INFORMANT Address MRS SHIRLEY BENNETT DAMERON Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sarcoïd 1380 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 3 1/2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Nov. 1 , 19 63 , to Nov 2 , 19 66 that (I) (we) last saw the deceased alive on Nov. 2 , 19 66 and that death occurred at 1234 M, from causes and on the date stated above.							
22a. SIGNATURE W.H. Patrick				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/3/1966	
22c. PHYSICIAN'S NAME (Type) W.H. PATRICK M.D.				22d. ADDRESS CALIFORNIA. MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BURIAL		NOV 5, 1966	ST PETER'S CLAVERS CEM.		RIDGE ST. MARY'S Md		
24. FUNERAL DIRECTOR JOHN M. WELCH				25a. REC'D BY REGISTRAR NOV 7 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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10137

RECEIVED

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TO HOLLY GARDNER, 10137
FROM: [illegible]
DATE: [illegible]
SUBJECT: [illegible]

16179

CERTIFICATE OF DEATH

16178

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Mary's Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Snouden Sylvester Chase</u>		4. DATE OF DEATH Month <u>November</u> Day <u>24</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cloored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 3, 1910</u>
9. AGE (In years last birthday) yrs. <u>56</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Henry Chase</u>		14. MOTHER'S MAIDEN NAME <u>Annie Jackson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs Theresa Thomas</u>		Address <u>Lexington Park, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Insufficiency</u> DUE TO (b) <u>Laemeric Carbonic Liver</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
INTERVAL BETWEEN ONSET AND DEATH <u>4-5 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>August 1966</u> to <u>Nov 1966</u> , that (I) (we) last saw the deceased alive on <u>Nov 1966</u> , and that death occurred at <u> </u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Ernest Rehn</u>		22b. DATE SIGNED <u>28 Nov 66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Ernest Rehn M. D.</u>		22d. ADDRESS <u>Lexington Park, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov. 28, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Face Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Great Mills, Maryland</u>
24. FUNERAL DIRECTOR <u>W. Clarke Mattingley</u>		25. REC'D BY REGISTRAR <u>Charles Judge</u>	
25a. REMOVAL (Specify) <u> </u>		25b. REGISTRAR'S SIGNATURE <u> </u>	

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101170

CERTIFICATE OF MARRIAGE

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22. Nov. 1901

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22. Nov. 1901

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22. Nov. 1901

22. Nov. 1901

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Mary's Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph Spencer Cusic</u>				4. DATE OF DEATH Month Day Year <u>November 8, 1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 31, 1888</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil Service</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>George P. Cusic</u>				14. MOTHER'S MAIDEN NAME <u>Cecelia Ann Adams</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-244231</u>		17. INFORMANT Address <u>Mrs Daisy A. Cusic Leonardtown, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture Aortic Aneurysm (abdominal)</u> 451X DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>10+ yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.							
22a. SIGNATURE <u>John F. Ferwick</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11-9-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>John F. Ferwick M. D.</u>				22d. ADDRESS <u>Leonardtown, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 11, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Aloysius Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Leonardtown, Maryland</u>	
24. FUNERAL DIRECTOR <u>W. Clarke Mattingley Leonardtown, Maryland</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 14 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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10-10-1967

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1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

510000 1. 200000

Synonym:

0. 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840.

2000-01-01

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

76

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|----------------------------------|---|--|---|---|---|---|--|---|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 16181 | | | | | 16180 | | | | |
| 1. PLACE OF DEATH
a. COUNTY ST. MARY'S MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ST. MARY'S | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
LEONARDTOWN | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
ABEEL, Md. | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
ST. MARY'S HOSPITAL | | | | | d. STREET ADDRESS | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First GEORGE Middle ALMORE Last DICKERSON | | | | | 4. DATE OF DEATH
Month NOVEMBER Day 20 Year 1966 | | | | |
| 5. SEX
MALE | 6. COLOR OR RACE
NEGRO | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
SEPT. 5, 1885 | | 9. AGE (In years last birthday) 81 yrs. | | IF UNDER 1 YEAR
Months 20 Days 19 Hours 66 Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
OYSTERMAN | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
ST. MARY'S, MARYLAND | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 13. FATHER'S NAME
GEORGE D.C. DICKERSON | | | | 14. MOTHER'S MAIDEN NAME
MARY VIRGINIA BRANSON | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
220-16-9128 | | 17. INFORMANT
ELIZABETH B. DICKERSON | | | Address
ABEEL, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
420.1 IMMEDIATE CAUSE (a) Coronary Failure Myocarditis Chronic
DUE TO (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____
DUE TO (c) _____ | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 1/26 , 19 54 to 1/20 , 19 66 that (I) (we) last saw the deceased alive on 1/1/20 19 66 and that death occurred at 9A M, from causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
Charles Greenwell | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | | | |
| 22c. PHYSICIAN'S NAME (Type)
CHARLES GREENWELL, M.D. | | | | 22d. ADDRESS
LEONARDTOWN, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
Nov. 23, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY
SACRED HEART | | | 23d. LOCATION (City or Town) (County) (State)
BUSHWOOD ST. MARY'S Md. | | |
| 24. FUNERAL DIRECTOR
W. CLARKE MATTINGLEY | | | | ADDRESS
LEONARDTOWN, Md. | | 25a. REC'D BY REGISTRAR
NOV 28 1966 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

4401

72131

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT

16182

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16181

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>St. Mary's</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Mechanicsville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Mechanicsville</u> | |
| c. LENGTH OF STAY IN 1b
<u>5 years</u> | | d. STREET ADDRESS
<u>18.1</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Mechanicsville, Md.</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First <u>Andrew</u> Middle <u>James</u> Last <u>Douglas</u> | | 4. DATE OF DEATH
Month <u>Nov</u> Day <u>#7</u> Year <u>1966</u> | |
| 5. SEX
<u>male</u> | 6. COLOR OR RACE
<u>colored</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>May 8, 1949</u> |
| 9. AGE (In years last birthday)
<u>17</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u>17</u> Days <u>17</u> Hours <u>17</u> Min. <u>17</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Farming</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Farming</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>John Jasper Douglas</u> | | 14. MOTHER'S MAIDEN NAME
<u>Agnes Marie Thomas</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<u>(If yes give war or dates of service)</u> | | 16. SOCIAL SECURITY NO.
<u>213-54-5652</u> | |
| 17. INFORMANT
<u>Father</u> | | Address
<u>same as # 2 above</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>FIBRINO-PURULENT PERITONITIS</u>
DUE TO <u>8254</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <u>LACERATION OF COLON</u>
DUE TO
(c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Passenger in automobile involved in accident.</u> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>Passenger in automobile involved in accident.</u> | |
| 20c. TIME OF INJURY Month, Day, Year
<u>7:00 p.m. 11 6 1966</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>street</u> | | 20f. (City or town) (County) (State)
<u>Route 302, 1 1/2 miles west of Mechanicsville, Md.</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
<u>Werner U. Spitz, M. D.</u> | | 22. DATE SIGNED
<u>Nov. 8th. 1966</u> | |
| EXAMINER'S NAME (Type)
<u>Werner U. Spitz, M. D.</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
Address (Street, city, town, or county)
<u>Nov. 8th. 1966</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>Nov. 10, 1966</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>St. Josephs Cemetery</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Morganza, Maryland</u> |
| 24. FUNERAL DIRECTOR
<u>W. Clarke Mattingley Leonardtown, Maryland</u> | | 25a. REC'D BY REGISTRAR
<u>NOV 14 1966</u> | |
| | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

18101

33291

3742 2-9

RECEIVED

18101

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 ~~M~~

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16183

CERTIFICATE OF DEATH

16182

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <i>St. Mary's</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <i>Maryland</i> b. COUNTY <i>St. Mary's</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Park Hall Rural</i> | | c. LENGTH OF STAY IN 1b
<i>3 years</i> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<i>Courtneys Nursing Home</i> | | d. STREET ADDRESS
<i>Rural Avenue</i> | |
| 3. NAME OF DECEASED (Type or print)
<i>James Richard Dyson</i> | | 4. DATE OF DEATH
<i>November 25, 1966</i> | |
| 5. SEX
<i>Male</i> | 6. COLOR OR RACE
<i>Colored</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>July 14, 1886</i> |
| 9. AGE (In years last birthday)
<i>80</i> yrs. | | 10. IF UNDER 1 YEAR
Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Waterman</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
<i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY
<i>U.S.A.</i> | |
| 13. FATHER'S NAME
<i>Richard Dyson</i> | | 14. MOTHER'S MAIDEN NAME
<i>Margaret Smother</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
<i>Thomas H. Dyson</i> | | Address
<i>Avenue, Maryland</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
<i>331X</i>
IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i>
DUE TO (b) <i>Arteriosclerosis</i>
DUE TO (c) <i>Myocardial Infarction</i> | | INTERVAL BETWEEN ONSET AND DEATH
<i>2 weeks</i>
<i>Wys.</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <i>19</i>
p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <i>Nov 14, 1966</i> to <i>Nov 25, 1966</i> , that (I) (we) last saw the deceased alive on <i>Nov 24, 1966</i> , and that death occurred at <i>11</i> M, from causes and on the date stated above. | | | |
| 21c. SIGNATURE
<i>Ernest Rehn M. D.</i> | | 21b. DATE SIGNED
<i>28 Nov 66</i> | |
| 22c. PHYSICIAN'S NAME (Type)
<i>Ernest Rehn M. D.</i> | | 22d. ADDRESS
<i>Lexington Park, Maryland</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | 23b. DATE THEREOF
<i>Nov. 28, 1966</i> | 23c. NAME OF CEMETERY OR CREMATORY
<i>Sacred Heart Cemetery</i> | 23d. LOCATION (City or Town) (County) (State)
<i>Bushwood, Maryland</i> |
| 24. FUNERAL DIRECTOR
<i>W. Clarke Mattingley</i> | | 25a. REC'D BY REGISTRAR
<i>Leonardtown, Maryland</i> | |
| 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | DATE
<i>NOV 29 1966</i> | |

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FOR STATE
HEALTH DEPT.

16184

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16183

| | | | | | |
|--|------------------------------------|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY ST. MARY'S MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ST. MARY'S | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
LEONARDTOWN | | c. LENGTH OF STAY IN 1b
D.O.A. | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
RURAL OAKLEY 18-1 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
ST. MARY'S HOSPITAL | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First EDWARD Middle FILLMORE Last JAMESON | | | 4. DATE OF DEATH
Month NOVEMBER Day 21 Year 1966 | | |
| 5. SEX
MALE | 6. COLOR OR RACE
COLORED | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
MAY 9, 1904 | | 9. AGE (In years last birthday) yrs. 62 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
BOILER OPERATOR | | 10b. KIND OF BUSINESS OR INDUSTRY
HOWARD UNIVERSITY | | 11. BIRTHPLACE (State or foreign country)
ABELL, MARYLAND | |
| 13. FATHER'S NAME
PHILIP JAMESON | | | 14. MOTHER'S MAIDEN NAME
SADIE FILLMORE | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
YES WW 11 | | 16. SOCIAL SECURITY NO.
214-16-7826 | | 17. INFORMANT
THELMA B. JAMESON Address OAKLEY, MARYLAND | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4200 Cardiac Arrhythmia
DUE TO (b) Arterio sclerotic H/D
DUE TO (c) 2 years | | | | | INTERVAL BETWEEN ONSET AND DEATH
2 years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE
William D. Boyd M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22. DATE SIGNED
11/22/66 | |
| EXAMINER'S NAME (Type) WILLIAM D. BOYD M. D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| Address (Street, city, town, or county) | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
Nov. 26, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY
ALL SAINTS CEMETERY | |
| 24. FUNERAL DIRECTOR
W. CLARKE MATTINGLEY | | ADDRESS
LEONARDTOWN, MARYLAND | | 25a. REC'D BY REGISTRAR
NOV 28 1966 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No.

16184

| | | | | | | | |
|---|---------------------------------|---|---|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>ST MARYS</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>CHARLES</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>LEONARDTOWN</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>WALDORF - RURAL</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>ST MARYS HOSPITAL</u> | | | | d. STREET ADDRESS
<u>RT 1 BOX 190</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
<u>LEONARD JOSEPH KELLER</u> | | | | 4. DATE OF DEATH
Month Day Year
<u>NOV. 16, 1966</u> | | | |
| 5. SEX
<u>MALE</u> | 6. COLOR OR RACE
<u>CAU.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>OCT. 3, 1896</u> | 9. AGE (In years last birthday)
<u>70</u> yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>FARMER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>TOBACCO</u> | | 11. BIRTHPLACE (State or foreign country)
<u>SWITZERLAND</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>LEONARD J. KELLER</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>REGINA SCHULER</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>217-36-7053</u> | | 17. INFORMANT
<u>GRACE KELLER, WALDORF, MD.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Thrombosis - recurrent</u>
4201 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerotic CV disease</u>
DUE TO (c) <u>6-7-42</u>
INTERVAL BETWEEN ONSET AND DEATH
<u>20 hrs</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>11/21/66</u> , 19 <u>66</u> , to <u>NOV. 16</u> , 19 <u>66</u> , that I last saw the deceased alive on <u>NOV. 16</u> , 19 <u>66</u> , and that death occurred at _____ M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>11-16-66</u> | | | | | | | |
| ACTUAL SIGNATURE <u>J. Roy Guyther</u> M.D. | | | | PHYSICIAN'S NAME (Type) <u>J. Roy Guyther M.D. MECHANICSVILLE, MD.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 22b. DATE THEREOF
<u>11-18-66</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>ST MARYS CEM.</u> | | 22d. LOCATION (City, town, or county) (State)
<u>BRYANTOWN MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>The Hunt Funeral Home, Waldorf, Md.</u> | | | | 24a. REC'D BY REGISTRAR
DATE <u>NOV 21 1966</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. (See pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.)

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
16186 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 16185

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY St. Mary's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY St. Mary's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Patuxent River | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
RURAL California | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Station Hospital | | d. STREET ADDRESS
Box 105 | |
| 3. NAME OF DECEASED (Type or print)
First Clifford Middle Stanley Last LONCAR | | 4. DATE OF DEATH
Month November Day 26 Year 1966 | |
| 5. SEX
Male | 6. COLOR OR RACE
Cau | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Aug. 29, 1945 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
CLERK SUPPLY DEPT. | | 10b. KIND OF BUSINESS OR INDUSTRY
US CIVIL SERVICE | 9. AGE (In years last birthday)
21 yrs. |
| 11. BIRTHPLACE (State or foreign country)
YOUNGSTOWN, OHIO | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Mr. Robert LONCAR | | 14. MOTHER'S MAIDEN NAME
MAXINE R. SILLIMAN | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
192 36 1541 | |
| 17. INFORMANT
MRS. DAVID STRAUB - SAME AS # 2 | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Injuries, Multiple
8254
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Automobile Accident
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH
25 min |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
Automobile Accident | |
| 20c. TIME OF INJURY
Month, Day, Year
0130 hour a.m. 11/26 19 66
p.m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Route #235 | 20f. (City or town) (County) (State)
Dameron St. Mary's Md. |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Elliot L. Marcus | | 22. DATE SIGNED
26 NOV 66 | |
| EXAMINER'S NAME (Type)
Elliot L. Marcus LT MC USNR | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
TRANSIT | 23b. DATE THEREOF
11/27/66 | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City, town or county) (State)
MIDLAND - BEAVER CO. PA. |
| 24. FUNERAL DIRECTOR
John M. Welch
JOHN M. WELCH - LEONARDTOWN, MD. | | 25a. REC'D BY REGISTRAR
NOV 29 1966
25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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U.S. ARMY
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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16187

CERTIFICATE OF DEATH

16186

| | | | |
|---|----------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY ST. MARYS MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ST. MARYS | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
RURAL - LEONARDTOWN | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
RURAL - LEONARDTOWN | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS
STAR RT: 42 | |
| 3. NAME OF DECEASED
(Type or print) MYRTLE ELIZABETH MAYOR | | 4. DATE OF DEATH
Month NOV. Day 28 Year 1966 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
11/10/1902 |
| 9. AGE (In years lost birthday)
64 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY
DOMESTIC | |
| 11. BIRTHPLACE (County & State, or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
EDWARD LEO RIDGELL | | 14. MOTHER'S MAIDEN NAME
JULIA PEGG | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
NO | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
LEONARD MAYOR SR. | | Address
SAME AS # 2 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ventricular Fibrillation
DUE TO Coronary Occlusion
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Artery Disease
(c) yes | | INTERVAL BETWEEN ONSET AND DEATH
yes | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Jan. 1966 to 11/28, 1966 that (I) yes lost saw the deceased alive on 11/28, 1966 , and that death occurred at 7:47 PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
J. Patrick Jarboe M.D. | | 22b. DATE SIGNED
11/30/66 | |
| 22c. PHYSICIAN'S NAME (Type)
J. PATRICK JARBOE M.D. | | 22d. ADDRESS
GREAT MILLS, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
12/1/1966 | |
| 23c. NAME OF CEMETERY OR CREMATORY
HOLY FACE CEM. | | 23d. LOCATION (City or Town) (County) (State)
GREAT MILLS, MARYLAND | |
| 24. FUNERAL DIRECTOR
JOHN M. WELCH - LEONARDTOWN, MD. | | 25a. REC'D BY REGISTRAR
DEC 5 1966 | |
| 25b. REGISTRAR'S SIGNATURE
James Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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U.S. GOVERNMENT PRINTING OFFICE: 1964
O - 350-017

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page-4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16188

CERTIFICATE OF DEATH

16187

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>St. Mary's</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Leonardtown</u> | | c. LENGTH OF STAY IN 1b
<u>88 days</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rural St. Mary's City</u> | | d. STREET ADDRESS
<u>18-1</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>St. Mary's Hospital</u> | | e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) <u>Theresa Therese Milburn</u> | | 4. DATE OF DEATH
Month <u>November</u> Day <u>20</u> Year <u>1966</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Nov. 22, 1879</u> |
| 9. AGE (In years last birthday)
<u>86</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>House wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u> </u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Isiah Holly</u> | | 14. MOTHER'S MAIDEN NAME
<u>Sally Naylor</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>Sol Milburn</u> | |
| 17. INFORMANT
<u>St. Mary's City, Maryland</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonia</u>
DUE TO <u>Cachexia & Pleural Effusion</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic Carcinoma of Thyroid</u>
(c) <u>Yes</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 wks</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan 11/20</u> , 19 <u>66</u> , to <u>11/20</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11/20</u> , 19 <u>66</u> , and that death occurred at <u>1:45</u> P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>[Signature]</u> | | 22b. DATE SIGNED
<u>11/21/66</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Dr. [Signature]</u> | | 22d. ADDRESS
<u>Great Mills, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>11-23-66</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>House of God Church</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Park Hall, Maryland</u> | |
| 24. FUNERAL DIRECTOR
<u>W. Clarke Mattingley, Leonardtown, Maryland</u> | | 25. REC'D BY REGISTRAR
<u>[Signature]</u> | |
| 25a. DATE
<u>DEC 28 1966</u> | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

52101

82121

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16189

CERTIFICATE OF DEATH

16188

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH
o. COUNTY St. Mary's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
o. STATE Maryland b. COUNTY St. Mary's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Patuxent River | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Lexington Park | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Station Hospital | | d. STREET ADDRESS
12 Salamua Court | |
| 3. NAME OF DECEASED (Type or print)
Ida Mae MILES | | 4. DATE OF DEATH
Month NOVEMBER Day 30 Year 19 66 | |
| 5. SEX
female | 6. COLOR OR RACE
Cau | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
June 14, 1912 |
| 9. AGE (In years last birthday)
54 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Julian BRINKLEY | | 14. MOTHER'S MAIDEN NAME
Blanche DRUREY | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Clair M. MILES Jr. | | Address
same as #2 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
053.3 Shock
IMMEDIATE CAUSE (a) Shock
DUE TO
(b) DU Fulminating Septicemia
DUE TO
(c) Gram negative rod | | | INTERVAL BETWEEN ONSET AND DEATH
10 hours |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>A.C. Robinson</i> | | 22b. DATE SIGNED
30 NOV 66 | |
| 22c. PHYSICIAN'S NAME (Type)
H.C. ROBISON LT MG USN | | 22d. ADDRESS
Same as #1 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
Dec. 5, 1966 | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National Cemetery | 23d. LOCATION (City or Town) (County) (State)
Arlington, Virginia |
| 24. FUNERAL DIRECTOR
W. Clarke Mattingley Leonardtown, Maryland | | 25a. REC'D BY REGISTRAR
DATE DEC 6 1966 | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> |

16182

RECEIVED BY MAIL

16182

21 JAN 38

1938

1938

TO THE DIRECTOR, BUREAU OF REVENUE
WASHINGTON, D. C.
FROM THE COMMISSIONER, BUREAU OF INTERNAL REVENUE
SUBJECT: [Illegible]
[Illegible text follows, including various administrative details and signatures.]

1
M
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|---|---|---|--|--------------------------------|--------------------------------------|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 16190 | | | | | | | | | | | |
| 16189 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY
St. Mary's County MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Frederick | | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Thurmont | | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Thurmont | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
St. Mary's Hospital | | | | | d. STREET ADDRESS
Leonardtown, Md Route 2 | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First Floyd Middle Victor Last Misner | | | | | 4. DATE OF DEATH
Month 11 Day 27 Year 1966 | | | | | | |
| 5. SEX
male | | 6. COLOR OR RACE
Caucasian | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
11-20-1892 | | 9. AGE (In years last birthday)
74 yrs. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
farmer | | 10b. KIND OF BUSINESS OR INDUSTRY
farm | | 11. BIRTHPLACE (County & State, or foreign country)
Frederick Co. Md. | | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | | | | |
| 13. FATHER'S NAME
Charles Misner | | | | | 14. MOTHER'S MAIDEN NAME
Fannie Wolf | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
no | | | | | 16. SOCIAL SECURITY NO.
213-01-9295 | | | | | | |
| | | | | | 17. INFORMANT
John Misner Rt. 2 Thurmont, Md. | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral hemorrhage
331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Generalized arteriosclerosis
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Cerebral hemorrhage 1965 | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
immediate
5 years | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at 1:50 AM, from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
P. J. BEAN M.D. | | | | | 22b. DATE SIGNED
Nov 27/66 | | | | | | |
| 22c. PHYSICIAN'S NAME (Type)
P. J. BEAN M.D. | | | | | 22d. ADDRESS
Thurmont, Md | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE THEREOF
11/30/1966 | | 23c. NAME OF CEMETERY OR CREMATORY
Creagerstown Cem. | | | 23d. LOCATION (City, town or county) (State)
Frederick Co. MD | | | |
| 24. FUNERAL DIRECTOR
Raymond E. Creager | | | 25a. REC'D BY REGISTRAR
DATE NOV 30 1966 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | | | | | |

16183

16183

513-01-9532

THOMSON SECURITY SYSTEMS, INC.
THOMSON SECURITY SYSTEMS, INC.

THOMSON SECURITY SYSTEMS, INC.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

16191

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16190

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 16. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>St. Mary's</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Leonardtoun</u> | | c. LENGTH OF STAY IN lb
<u>26 hrs</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>St. Mary's Hospital</u> | | e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Dennis</u> Middle <u>Reginald</u> Last <u>Norris</u> | | 4. DATE OF DEATH
Month <u>November</u> Day <u>14</u> Year <u>1966</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Sept. 25, 1949</u> |
| 9. AGE (In years last birthday)
<u>17</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u>17</u> Days <u>17</u> Hours <u>17</u> Min. <u>17</u> | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 12. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | |
| 13. FATHER'S NAME
<u>J. Jennifer Norris</u> | | 14. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
<u>Father</u> | | Address
<u>same as # 2 above</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Gun Shot</u>
DUE TO (b) <u>9190</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>26 hrs</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>Shot himself pulling gun out of car by the barrel</u> | |
| 20c. TIME OF INJURY Month, Day, Year
<u>5:55</u> Hour <u>am</u> <u>11-13</u> 19 <u>66</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>at home</u> | 20f. (City or town) (County) (State)
<u>Great Mills</u> <u>St Marys</u> <u>MD</u> |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
<u>William D. Boyd M. D.</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type)
<u>William D. Boyd M. D.</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | Address (Street, city, town, or county)
<u>11/16/66</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>Nov. 17, 1966</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Holy Face Cemetery</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Great Mills</u> <u>Maryland</u> |
| 24. FUNERAL DIRECTOR
<u>W. Clarke Mattingley Leonardtoun, Maryland</u> | | 25. REC'D BY REGISTRAR
DATE <u>NOV 17 1966</u> | |
| | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

CERTIFICATE OF DEATH

16192

16194

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <i>St. Mary's</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <i>Maryland</i> b. COUNTY <i>St. Mary's</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Leonardtown</i> | | c. LENGTH OF STAY IN 1b
<i>18 days</i> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<i>St. Mary's Hospital</i> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <i>James</i> Middle <i>D.</i> Last <i>Owen</i> | | 4. DATE OF DEATH
Month <i>November</i> Day <i>22</i> Year <i>1966</i> | |
| 5. SEX
<i>Male</i> | 6. COLOR OR RACE
<i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>April 3, 1882</i> |
| 9. AGE (In years last birthday)
<i>84</i> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Farming</i> | 11. BIRTHPLACE (County & State, or foreign country)
<i>Virginia</i> |
| 10b. KIND OF BUSINESS OR INDUSTRY | | 12. CITIZEN OF WHAT COUNTRY?
<i>U. S. A.</i> | |
| 13. FATHER'S NAME
<i>Tom Owen</i> | | 14. MOTHER'S MAIDEN NAME
<i>Belle Greene</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
<i>228-28-2679</i> | |
| 17. INFORMANT
<i>Mrs Kate E. Owens</i> | | Address
<i>California, Maryland</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Ventricular Fibrillation</i>
DUE TO (b) <i>Coronary Occlusion</i>
DUE TO (c) <i>Arteriosclerosis</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <i>19</i>
p.m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <i>Jan. 1966</i> to <i>11/22, 1966</i> , that (I) (we) last saw the deceased alive on <i>11/22, 1966</i> , and that death occurred at <i>9:57 A.M.</i> from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>James P. Jarboe M. D.</i> | | 22b. DATE SIGNED
<i>11/22, 1966</i> | |
| 22c. PHYSICIAN'S NAME (Type)
<i>James P. Jarboe M. D.</i> | | 22d. ADDRESS
<i>Great Mills, Maryland</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | 23b. DATE THEREOF
<i>Nov. 25, 1966</i> | 23c. NAME OF CEMETERY OR CREMATORY
<i>Joy Chapel Cemetery</i> | 23d. LOCATION (City or Town) (County) (State)
<i>Hollywood, Maryland</i> |
| 24. FUNERAL DIRECTOR
<i>W. Clarke Mattingley, Leonardtown, Maryland</i> | | 25a. REC'D BY REGISTRAR
<i>NOV 28 1966</i> | |
| | | 25b. REGISTRAR'S SIGNATURE
<i>Charles J. J...</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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(M)

16193

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16192

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY ST. MARY'S MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ST. MARY'S | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
LEONARDTOWN | | c. LENGTH OF STAY IN TB
1 DAY | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
RURAL PINEY POINT | | d. STREET ADDRESS
18-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
ST. MARY'S HOSPITAL | | e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 3. NAME OF DECEASED (Type or print)
First EUGENE Middle MATTHEW Last PURCELL | | 4. DATE OF DEATH
Month NOVEMBER Day 21 Year 1966 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Nov. 1, 1886 |
| 9. AGE (In years lost birthday)
80 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min.
IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HAT FINISHER | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
PINEY POINT, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
THOMAS T. PURCELL | | 14. MOTHER'S MAIDEN NAME
? ? | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
215-32-0466 | |
| 17. INFORMANT
MRS WILMER M. KERBE | | Address
1232 BREWSTER STREET | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
5271 IMMEDIATE CAUSE (a) Circulatory Collapse
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Bronchopneumonia
DUE TO
(c) Emphysema | | INTERVAL BETWEEN ONSET AND DEATH
4 days
YES | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 11/21/66 to 11/21/66 , that (I) (we) lost the deceased alive on 11/21/66 , and that death occurred at 9 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
J. Patrick Jarboe M. D. | | 22b. DATE SIGNED
11/22/66 | |
| 22c. PHYSICIAN'S NAME (Type)
J. Patrick Jarboe M. D. | | 22d. ADDRESS
Great Mills, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
Nov. 25, 1966 | |
| 23c. NAME OF CEMETERY OR CREMATORY
TRINITY EPISCOPAL | | 23d. LOCATION (City or Town) (County) (State)
ST. MARY'S CITY, MARYLAND | |
| 24. FUNERAL DIRECTOR
W. CLARKE MATTINGLEY | | 25a. REC'D BY REGISTRAR
NOV 28 1966 | |
| 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | | |

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16194

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16193

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|---|------------------------------------|---|--|--|--|---|---|
| 1. PLACE OF DEATH
o. COUNTY St. Mary's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY St. Mary's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Leonardtown | | | c. LENGTH OF STAY IN 1b
DOA | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Compton 18.1 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Mary's Hospital | | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
HORACE BERNARD ROBINSON | | | | 4. DATE OF DEATH
Month Day Year
November 13 19 66 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Jan. 23, 1946 | | 9. AGE (In years lost birthday) yrs.
20 | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
Horace Robinson | | | | 14. MOTHER'S MAIDEN NAME
Mary Florine Turner | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address
Mother same as # 2 above | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple Gunshot wounds of Chest
981X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) DUE TO
(c) DUE TO | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Was shot in chest | | | | |
| 20c. TIME OF INJURY Month, Day, Year
11:00 p.m. 11/12 19 66 | | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not While of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Leonardtown | | 20f. (City or town) (County) (State)
Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
Rudiger Breitenecker, M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
Address (Street, city, town, or county) | | 22. DATE SIGNED
11/13/66 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Nov. 17, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Francis Xavier | | 23d. LOCATION (City or Town) (County) (State)
Compton, Maryland | |
| 24. FUNERAL DIRECTOR
W. Clarke Mattingley Leonardtown, Maryland | | | | 25a. REC'D BY REGISTRAR
DATE NOV 16 1966 | | 25b. REGISTRAR'S SIGNATURE
f Charles Judge | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16195

CERTIFICATE OF DEATH

16194

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>St. Mary's</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Leonardtown</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rural Clements</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>St. Mary's Hospital</u> | | d. STREET ADDRESS
<u>18.1</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Edward</u> Middle <u>James</u> Last <u>Russell</u> | | 4. DATE OF DEATH
Month <u>November</u> Day <u>18</u> Year <u>1966</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>July 15, 1894</u> |
| 9. AGE (In years last birthday)
<u>72</u> yrs. | | IF UNDER 1 YEAR
Months <u>18</u> Days <u>19</u> Hours <u>66</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Farming & Carpenter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Clements, Maryland</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Jackson P. Russell</u> | | 14. MOTHER'S MAIDEN NAME
<u>Martha Farr</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give year or dates of service) <u>WW I</u> | | 16. SOCIAL SECURITY NO.
<u>214-34-2751</u> | |
| 17. INFORMANT
<u>Mary Emily Russell</u> | | Address
<u>Clements, Maryland</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>PROBABLE CARCINOMA LUNG</u>
163X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>BRONCHIECTASIS</u>
DUE TO
(c) <u>5 YRS</u> | | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 YR</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>DIABETES MELLITUS, EMPHYSEMA</u> | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u> p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>JAN</u> , 19 <u>48</u> , to <u>Nov 18, 1966</u> , that (I) (we) last saw the deceased alive on <u>Nov 17, 1966</u> , and that death occurred at <u>M</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Ray Gentry</u> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
<u>XXXXXX XXXXX XXXXX</u> | | 22d. ADDRESS
<u>XXXXXX XXXXX XXXXX</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>Nov. 20, 1966</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>St. Josephs</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Morganza, Md.</u> |
| 24. FUNERAL DIRECTOR
<u>W. Clarke Mattingley Leonardtown, Maryland</u> | | 25a. REC'D BY REGISTRAR
<u>NOV 21 1966</u> | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> |

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RECEIPT OF DEBIT

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16196

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16195

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY St. Mary's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY St. Mary's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Lexington Park | | c. LENGTH OF STAY IN 1b
18/1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS
Box 85, Route 2 | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) Lucinda First Hoodly Middle Schofield Last | | 4. DATE OF DEATH
Month Nov. Day 18 Year 1966 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
6 - 10 - 1948 |
| 9. AGE (In years last birthday) 18 yrs. | | 10. IF UNDER 1 Year Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Secretary | | 10b. KIND OF BUSINESS OR INDUSTRY
Furniture Sales | |
| 11. BIRTHPLACE (State or foreign country)
Greenwich, Conn. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Earle F. Schofield, Jr. | | 14. MOTHER'S MAIDEN NAME
Millie Kaneruck | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
215 50 0155 | |
| 17. INFORMANT
Earle F. Schofield, Jr. - California, Md. | | Address Box 85 Rt. 2 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Crushing injuries of Head right chest
DUE TO through -
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Auto accident Rt. 235 Lexington Park Maryland. | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 9:45 p.m. Nov 18 1966 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Lexington Park | | 20f. (City or town) (County) (State)
Stomps | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE W. H. Patrick | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) W. H. Patrick, M.D. | | ASS. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22. DATE SIGNED
11-14-66 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
TRANSIT | | 23b. DATE THEREOF
11/20/66 | |
| 23c. NAME OF CEMETERY OR CREMATORY
GREENWICH, CONNECTICUT | | 23d. LOCATION (City or Town) (County) (State)
Leonardtown, Md. | |
| 23e. REC'D BY REGISTRAR
DATE NOV 22 1966 | | 23f. REGISTRAR'S SIGNATURE
Charles Judge | |

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16197

CERTIFICATE OF DEATH

16196

| | | | | | | | |
|--|----------------------------------|---|---|---|--------------------------------|--|--------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>St. Mary's</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Hollywood</u> | | | | c. LENGTH OF STAY IN 1b
<u>25 years</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | d. STREET ADDRESS
<u>Rt 1 Box 218</u> | | | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
<u>Olive</u> <u>XXXX J.</u> <u>Taylor</u> | | | | 4. DATE OF DEATH Month Day Year
<u>November</u> <u>6</u> , 19 <u>66</u> | | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Nov. 5, 1915</u> | 9. AGE (In years last birthday)
<u>51</u> yrs. | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Teacher</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
<u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
<u>Walter R. Judd</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Marion Silvery</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>218-28-0131</u> | | 17. INFORMANT Address
<u>Floyd F. Dean Rt. 1 Box 218 Hollywood, Md.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma of the Ovary.</u>
1750
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b)
DUE TO
(c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 year</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
of work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 1, 1966</u> to <u>Nov. 6, 1966</u> that (I) (we) last saw the deceased alive on <u>Nov 6, 1966</u> and that death occurred at <u>7:15</u> M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>W.H. Patrick</u> | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>11-8-66</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>William H. Patrick M.D.</u> | | | | 22d. ADDRESS
<u>Lexington Park, Maryland</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>Nov. 8, 1966</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Trinity Memorial Gardens</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Waldorf, Maryland</u> | |
| 24. FUNERAL DIRECTOR
<u>W. Clarke Mattingley Leonardtown, Maryland</u> | | | | 25a. REC'D BY REGISTRAR
DATE <u>NOV 14 1966</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

10191

CERTIFICATE OF DEATH

10191

| | | | |
|------------------------|--|------------------------|--|
| Name of Deceased | | Date of Death | |
| John Doe | | Jan 1, 1900 | |
| Age | | Sex | |
| 35 years | | Male | |
| Place of Birth | | Cause of Death | |
| New York City | | Heart Disease | |
| Occupation | | Signature of Physician | |
| Teacher | | J. H. Smith | |
| Signature of Registrar | | Date of Registration | |
| A. B. Jones | | Jan 5, 1900 | |
| Place of Death | | Signature of Coroner | |
| Home | | C. D. White | |
| Burial Place | | Remarks | |
| Cemetery | | No other remarks | |

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16198

CERTIFICATE OF DEATH

16197

| | | | | | | | |
|---|--|---|--|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>St. Mary's</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Leonardtown</u> | | c. LENGTH OF STAY IN 1b
<u>2 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Piney Point</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>St. Mary's Hospital</u> | | | | d. STREET ADDRESS
<u>181</u> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Helen</u> Middle <u>Edna</u> Last <u>Thompson</u> | | | | 4. DATE OF DEATH
Month <u>November</u> Day <u>30</u> Year <u>1966</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>Colored</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH
<u>May 15, 1909</u> | |
| 9. AGE (In years last birthday) <u>57</u> yrs. | | IF UNDER 1 YEAR
Months <u>30</u> Days <u>19</u> Hours <u>66</u> Min. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Cook</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Maryland</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>U.S.A.</u> | | | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | |
| 13. FATHER'S NAME
<u>Perry Robinson</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Ida Gross</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>213-22-0658</u> | | 17. INFORMANT
<u>Rudolph J. Robinson</u> Address <u>Piney Point, Maryland</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u>
DUE TO <u>294X</u>
(b) <u>Polycythemia</u>
DUE TO <u>Unknown</u>
(c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u> p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>29 Nov, 1966</u> , to <u>30 Nov, 1966</u> , that (I) (we) lost saw the deceased alive on <u>30 Nov, 1966</u> , and that death occurred at <u>11:00</u> M, from causes on and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Ernest M. Rehm</u> | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>2 Dec 1966</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Ernest Rehm M. D.</u> | | | | 22d. ADDRESS
<u>Lexington Park, Maryland</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>Dec. 3, 1966</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>St. Marks</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Valley Lee, Maryland</u> | |
| 24. FUNERAL DIRECTOR
<u>W. Clarke Mattingley</u> | | | | ADDRESS
<u>Leonardtown, Maryland</u> | | 25a. REC'D BY REGISTRAR
DATE <u>DEC 3 1966</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>J. Charles Judge</u> | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

50131

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 6 Film G382 11/18/66 kk
MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16199

16198

| | | | |
|--|----------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY
ST. MARY,S
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
DAMERON - RURAL
c. LENGTH OF STAY IN 1b
DAMERON - RURAL
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
MARYLAND
b. COUNTY
ST. MARY,S
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
DAMERON - RURAL
d. STREET ADDRESS
181
e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
ALICE EDNA TROSSBACH | | 4. DATE OF DEATH
Month Day Year
NOVEMBER 7 19 66 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
8-26-1901 |
| 9. AGE (In years lost birthday) yrs.
65 | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEKEEPER | | 10b. KIND OF BUSINESS OR INDUSTRY
DOMESTIC | |
| 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
CHARLES McKAY | | 14. MOTHER'S MAIDEN NAME
RUTH BOHANAN | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
219-42-2807 | |
| 17. INFORMANT
WILLIAM HENRY TROSSBACH - DAMERON MD. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Infarction
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b)
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | INTERVAL BETWEEN ONSET AND DEATH
18.1 | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m.
19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
WM.D. BOYD M.D. | | 22. DATE SIGNED
11/9/66 | |
| EXAMINER'S NAME (Type)
WM.D. BOYD M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
Address (Street, city, town, or county) ST. MARYS | |
| 23a. BURIAL, CREMATION, or other (Specify)
BURIAL | | 23b. DATE THEREOF
11/10/66 | |
| 23c. NAME OF CEMETERY OR CREMATORY
ST. MICHAELS CEM. | | 23d. LOCATION (City or Town) (County) (State)
RDXX RIDGE, MARYLAND | |
| 24. FUNERAL DIRECTOR
JOHN M. WELCH - LEONARDTOWN, MD. | | 25a. REC'D BY REGISTRAR
NOV 14 1966 | |
| | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

20131

03121

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

76

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16200

CERTIFICATE OF DEATH

16199

| | | | |
|--|----------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY
ST. MARY'S | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
MARYLAND
b. COUNTY
ST. MARY'S | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
LEONARDTOWN | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
LEONARDTOWN | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
ST. MARY'S HOSPITAL | | d. STREET ADDRESS
LEONARDTOWN, Md. | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
MARY FRANCES YOUNG | | 4. DATE OF DEATH
Month Day Year
NOVEMBER 14 19 66 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
NEGRO | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
12-17-1911 |
| 9. AGE (In years lost birthday)
54 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY
DOMESTIC | |
| 11. BIRTHPLACE (County & State, or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
COLTON YATES | | 14. MOTHER'S MAIDEN NAME
ELEANORA NEAL | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
NO | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
STEPHEN R. L. YOUNG | | Address
LEONARDTOWN | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia
592 X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic renal Disease (pyelonephritis). DUE TO
(c) 20 yr. | | INTERVAL BETWEEN ONSET AND DEATH
1 year | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
John F. Fenwick | | 22b. DATE SIGNED
11-16-66 | |
| 22c. PHYSICIAN'S NAME (Type)
JOHN F. FENWICK M.D. | | 22d. ADDRESS
LEONARDTOWN MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
11-17-66 | |
| 23c. NAME OF CEMETERY OR CREMATORY
OUR LADY'S CEM. | | 23d. LOCATION (City or Town) (County) (State)
ST MARY'S COUNTY MARYLAND | |
| 24. FUNERAL DIRECTOR
John M. Welch
JOHN M. WELCH - LEONARDTOWN, MD. | | 25a. REC'D BY REGISTRAR
NOV 21 1966 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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